Virginia Perinatal Hepatitis B Prevention (VPHBP) Program
Infant Information Form

PLEASE REPORT ONLY BABIES BORN TO HBsAg POSITIVE MOTHERS

Mother's Case No. _____

Mother's Name: _____
Last First Middle

Mother's Address: _____

_____ **Phone No:** _____

Name and Address of Physician Who Will Provide Care to Infant After Hospital Discharge:

Name: _____

Address: _____

_____ Phone No:_____

Infant Information:

Name: _____
Last First Middle

Date of Birth: _____/_____/_____ Sex: Male ( ) Female: ( )
Month Day Year

Vaccine Information:

HBIG Given: Yes ( ) No ( ) Date Given: _____/_____/_____
Month Day Year

How many **hours** after birth was HBIG given? _____ hours

HBV1 Given: Yes ( ) No ( ) Date Given: _____/_____/_____
Month Day Year

How many **hours** after birth was the first dose of hepatitis B vaccine given?_____ hours

Name of Hospital: _____

Address: _____

_____

Would you like HBIG and hepatitis B vaccine shipped to you to replace the HBIG and vaccine given to this infant?

( ) **Yes,** please replace the HBIG and hepatitis B vaccine given to the above named infant.

( ) **No**, replacement HBIG and hepatitis B vaccine is not necessary.

Form completed by: (Please Print)

_____

Phone #: _____

12/03

J PLEASE RETURN FORM TO:

Marie Krauss, VPHBP Program Coordinator
Virginia Dept of Health
Division of Immunization - Room 314- West
P.O. Box 2448
Richmond, Virginia 23218
Phone: 1-800-568-1929